

ImpAct

May 1999 Volume 1 Issue 1

- *sharing experience*
- *defining good practice*
- *improving service delivery*
- *supporting learning in the NHS*

NHS Learning Network

Welcome to the first edition of *ImpAct*, a new publication from the *Bandolier* stable. While *Bandolier* concentrates on evidence around efficacy of treatment, *ImpAct* will be focusing on ways of raising standards and improving the delivery of services to patients. We want to concentrate on those things that make the NHS *better*.

ImpAct is about 'good practice' - and about **implementing change** and **action** to get there! Our aim will be to help people in the NHS who can make a difference, and to identify and report on:

- ◆ Ways of improving performance which have been successful and which are transferable. Reports will include *ImpAct* bottom lines to help readers pick up lessons from the work.
- ◆ People who have led successful local initiatives and who are keen for others to learn from their experience. Reports will provide contact details.
- ◆ Material developed locally that could be adapted for use elsewhere and thus cut local development time. Reports will identify material that is available.

What *ImpAct* will cover?

We aim to cover a full range of challenges facing clinicians and managers in the NHS - specifically those about:

- ⇒ clinical governance and questions about clinical quality, such as the application of National Service Frameworks
- ⇒ emergency pressures, demand, and waiting times
- ⇒ integration of services across institutional boundaries
- ⇒ primary care groups and questions about service delivery
- ⇒ involving patients and the public
- ⇒ developments in human resources like staffing and skill mix issues.

High standards will be set and we will be developing criteria to guide the choice of initiatives which we cover. This will allow readers to be confident that the work reported is worthy of attention. Factors to be taken into account will confirm that the approach:

- ✓ both works, and that information to describe the benefits to patients and organisations is available
- ✓ is transferable and not likely to be unique to the local situation
- ✓ should be affordable within normal budgets - and not require significant pump-priming funds

Tell one, get one free!

In this first edition we have described some initiatives to illustrate the way that our reports will be presented. This is new territory, so if you have ideas about what information you want, or how you want it, let us know. Our links with the 'NHS Learning Network' and the proposed NHS Learning Centres will help us identify initiatives that merit attention. Links with other relevant initiatives will also be created, such as the national R&D and IT programmes.

We want clinicians and managers in the NHS to use *ImpAct* to tell others about the good practice they have established - and how it was achieved. Many aspects of good practice evolve from determined efforts to tackle difficult local problems. We all face different problems - but why re-invent the wheel? It could be like shopping - not buy one, get one free - but tell one, get one free!

What you can do

If you have improved local services in ways that you would like to share with your NHS colleagues we want to hear from you. Don't worry about if you don't have the time to write up your work - or are not used to writing - we will help you.

In future editions there will be an *ImpAct* notice board - to allow readers to identify problems they are facing and where they can compare notes and experiences with others. We would also like you to tell us what is in your 'too difficult' box. We will be developing electronic pages as part of the *Bandolier* Internet site to complement the paper version of *ImpAct*, and we will tell you about this in future editions.

Our supporters

ImpAct is supported by the NHS Executive to complement the NHS Learning Network. This major initiative is promoting the sharing and adoption of good practice across the NHS.

We are pleased that Dr Jennifer Dixon from the NHS Executive, Dr Naomi Fulop from the National R&D Service Development and Organisation programme and Dr Nicholas Hicks currently seconded from the NHS to the Department of Health will form our Editorial Board. On pages 7&8, Jennifer describes the plans for the NHS Learning Network. We will keep readers up to date as the initiative develops.

You can get in touch with us at the *Bandolier* office: Fax 01865 226978 or contact us by email.

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AN A-Z OF WINTER PRESSURES

Managing emergency admissions at Birmingham Heartlands and Solihull Trust (Teaching).

Why was the initiative launched?

Like all hospitals, Birmingham Heartlands and Solihull is faced each year with the need to plan and respond to a growth in emergency admissions during the Winter. For the Winter 1997/98, the hospital was determined to learn from its experience in previous years and put in place robust and effective plans to manage future Winter pressures.

What was done?

The work was directed by a 'Winter Pressures Group' chaired by the Trust's Medical Director - Dr Craig Skinner - and involving all the senior staff of the hospital responsible for the management of emergency medical beds in the Trust. They collated and analysed information about emergency activity in previous Winters. This provided the group with a detailed picture of how the Trust had managed the increased demand in its past. A 'bed model' was then developed, providing a basis to plan for the future. The group found ways to bring together independently formulated policies, such as: trolley wait protocols, ward round protocols and discharge policies.

An important product from the work of the group has been the creation of 'The A-Z of Winter Pressures'. This is a detailed reference guide to all initiatives used to meet increased demands of Winter. The A-Z sets out the roles and responsibilities of key individuals within the Trust and the resources available to them. In addition, the A-Z provides a summary of all the plans and initiatives developed by health authority, the local authority and the Trust. The main areas covered in the A-Z are shown in the Table below.

The A-Z also includes detailed contingency arrangements indicating when the emerging situation demands action. 'Trigger points' - linked to plans for bed management meetings - are defined. These - Stage I: Green, Stage 2: Yellow, and Stage 3: Red - indicate the urgency of response required and provide guidance about who will do what and what action should be taken.

Does it work?

The system has now been in place for two Winters and the benefits of the approach are already being felt. The level of emergency admissions in Winter 1997/98 were low, particularly in January, and did not place undue pressures on the system. A detailed review of its performance showed the system to work well. This review included discussion groups to enable staff in the hospital to 'have their say' about whether the new system worked. A number of useful comments came out of these discussions, such as support for a 'one-stop' contact for facilities services.

Two examples of specific improvements arising from the work and achieved during 1997/98 are:

- 1 Additional multi-disciplinary staffing was able to reduce discharge delays - down 27% from the previous Winter.
- 2 Introduction of a locum GP within A&E was effective in reducing waiting times for patients to be seen and preventing inappropriate admissions.

During 1998 the Trust added to its 'Winter pressure' initiative. For example 'step down' beds have been identified in Nursing Homes and Residential Homes providing rapid access for GPs and Nursing Teams to prevent admission and for the Trust to facilitate early discharge. Other initiatives, such as the creation of a Home Care Team, were possible because of Winter Pressures funds. As well as developing specialist services the focus was placed on the needs of the elderly.

A detailed analysis of activity in Winter 1998/99 is being undertaken. Early indications are that the hospital coped with the increased demand created by the 'flu epidemic in January 1999. Use of the systems has limited any impact on surgical elective work at the hospital. Moreover, the Trust was able to complete an ambitious waiting list initiative a month earlier than planned.

Tips for success

- ✓ Commitment and leadership from the Chief Executive is essential - it must be 'real' and active - not 'tokenism'.

An A-Z of Winter pressures

A&E	Contingency Plans	Recruitment
Admission	Deflects	Retention - Nursing
Alerts - Green - Yellow - Red	Discharge Lounges	Situation Reports
Annual leave	Equipment	Social services
Bed Bureau	Media calls	Specialist nurses
Bed Management	Medical Cover - Winter Wards	Step-down beds
Bed Meetings	Monitoring staff levels	Surgery
Bonus Schemes	Nurse Advisers on call	Trigger points
CART	Operations director	Ward opening . . .and closing
Community Services	Performance Management	Ward round protocols
Consultant of the day	Professions Allied to Medicine	

- ✓ Identify a senior inter-disciplinary team - led from Director level - to manage the work. Key tasks are: providing a 'finger on the pulse'; monitoring the overall situation and keeping systems and action taken under review.
- ✓ Involvement of local staff side interests ensuring the impact of any new systems on staff are adequately examined.
- ✓ Ensuring that all staff in the organisation are kept in touch with progress. Make sure they know 'how well they are doing' and about contingency plans should demand increase. Find ways to pass information through regular 'roadshows' and 'briefings' - in ways that take account of clinical commitments and shift patterns.

To find out more contact

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 Birmingham B9 5SS

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Copies of 'The A-Z of Winter Pressures' are available.

ImpAct bottom lines

- ⇒ Active - senior - leadership is important when tasks require co-ordination across large (and small!) organisations.
- ⇒ Time devoted to communications and ensuring that staff affected by initiatives 'know what is going on' is never wasted.

A STANDARDS APPROACH TO CLINICAL QUALITY

Developing primary care in East Kent.

Why was the initiative launched?

The Primary Care Clinical Effectiveness programme (PRICCE) was launched in April 1998 to help general practitioners and primary care teams in East Kent to improve quality of care. The programme consists of a package of evidence-based criteria and developmental support to help primary care teams improve their care in a systematic way. A series of proxy measures complement the standards to allow progress to be measured. Practices are rewarded for demonstrating that they have met the clinical standards.

What is being done?

A set of clinical standards form the bedrock of the programme. They provide a framework within which general practitioners and their teams can improve their clinical services. The standards were developed by a multi-disciplinary team from the health authority, local primary care, and specialists from around the country. An important contribution was made also by the Health Services Accreditation Unit. Thirteen clinical conditions were chosen - those most common or which caused particular long-term problems for patients. The health authority also developed a set of standards to guide the development of primary care administrative systems.

Example of the local standards: Myocardial Infarction.

- ◆ All patients with a myocardial infarction since 1/4/1998 must have (specified) information recorded in their notes, unless a contraindication is documented.
- ◆ Data from the secondary sector, eg exercise test results, ECG results, lipid profile, review dates.

- ◆ Medication the patient is on and why: aspirin, beta blockers, ACE inhibitors.

The clinical standards specify the proportion of patients that should be recorded, eg by 1/4/99, 80% of MI patients should have this recorded (and 90% by 1/4/01).

Disease areas covered

Angina
Asthma
Atrial fibrillation
Chronic heart failure
Depression
Diabetes
Dyspepsia
Epilepsy
Urinary tract infection
Hypertension
High cholesterol
Myocardial infarction
Venous leg ulcers

How it works

GPs are invited to apply to join the programme - and if successful receive a grant £3,000 (per full time GP, per year) as a contribution to the costs of the work involved. They are free to use the grant in any way they choose. A series of 'entry criteria' has been established - such as the availability of disease registers and written clinical protocols. GPs have to 'sign-up' to audits to demonstrate compliance with the standards. Payment is subject to satisfactory progress reports. In 1998/99 102 GPs from 26 practices were accepted into the programme - about a quarter of the local practices.

Entry criteria - apply to all disease areas

Disease registers set up
Written protocols undertaken by team members
Complete audits undertaken to demonstrate compliance

Special arrangements have been made to enable practices working within deprived areas to join the programme - with an incremental approach to the achievement of standards.

Two main activities have been put in place to support practices' involvement in the programme.

1 GP Support Groups allow problems being faced by individual GP and practices to be discussed and resolved. These are centred on local hospitals so that hospital consultants can support them. The groups are facilitated by staff from the health authority and encourage multi-disciplinary working. Typically the groups meet every two months with discussions covering a variety of topics from IT systems and data capture to questions about clinical practice. The meetings are approved for educational purposes and have been well received - a GP attending one of such meetings said:

- *'It is good to be going to meetings which are truly educational and which actually make me change my practice'.*
- 2 Support from the local MAAG office to explore questions about the presentation and interpretation of data and in devising suitable audits. The MAAG office has created a set of 'Read' codes for use within the programme. All of the work undertaken between the practices and the MAAG remains confidential - with detailed reports not open to the health authority.

Does it work?

A number of benefits are emerging from informal discussions with practices and the Support Groups even though no formal evaluation has yet been established. Examples are:

Discussions in the Support Groups are showing that individual clinicians are starting to change the nature and quality of care they provide to patients. Practices are creating disease registers to allow them to recall patients so that their treatment can be reviewed. Even when the practice standards have not been met in full, significant improvements in outcomes for patients are already being secured.

- One GP has said *'It's created a buzz in the practice and given us a very positive focus. Patient care has definitely improved'*.

More productive contact between GPs and hospital consultants is evident - particularly where co-ordinated care is nec-

essary to achieve the standards. Consultants are acquiring a better understanding of the needs of primary care. Two examples are:

- GPs were concerned that they would be unable to meet the agreed standards for the care of patients with diabetes because of variations in the services provided from local hospitals. Subsequent discussions between GPs and Consultants have encouraged the three local hospital laboratories to adopt common reporting standards - they previously had different reporting levels.
- The diagnosis of urinary infection in babies is difficult because of the difficulty in collecting urine samples. Following discussions between GPs and Consultants a novel and effective means of collecting samples through the use of sanitary towels has been developed.

Participation in the programme is changing the ways in which practice teams work together and placing emphasis on teamwork as well as clinical practice.

Tips for success

Some early pointers to success are :

- ✓ Create 'safe' occasions when questions about quality of clinical practice can be openly discussed. These occasions must allow individual clinicians - GPs and other disciplines - to voice their uncertainty and lack of knowledge. Help them to change - don't simply expect it to happen.
- ✓ Success depends on effective and consistent use of information and IT systems. Experience has shown that practices with a history of activity in particular disease areas are able to achieve the standards. Conversely, where there has been little such history, practices are finding it difficult to meet the standards. Accurate, detailed databases and disease registers are the keys to success. However, building these is a significant workload for most practices - but the exercise will prove an invaluable way of discovering patients who were 'slipping through the net'

To find out more contact

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An information pack, including the detailed clinical standards for the thirteen conditions, entry criteria for the programme and proxy outcome measures being used in East Kent is available. It costs £10 to cover printing and postage.

ImpAct bottom line

⇒ Find novel ways of tackling problems. This programme is a good example where local standards were set - but practices were allowed to find their own ways to deliver those standards.

DEVELOPING THE ROLE OF NURSE PRACTITIONERS

Managing demand and exploring new roles at Milton Keynes Hospital

Why was the initiative launched?

The creation of nurse practitioner posts was seen as a practical way of ensuring that a full service was offered to patients. Pressure on clinical resources and the consequences of the reduction in junior doctors hours had already stimulated staff in the hospital to look for ways to improve the use of resources.

Part of the problem was the inherent difficulty of balancing service and teaching needs in an ordinary district general hospital. They lack the flexibility available in teaching hospitals with their higher staff numbers overall. It was proving difficult to ensure that junior doctors were able to experience the full training cycle - from observation to application - during their six-month placement. Ways needed to be found to streamline the process and speed up patient management.

What was done?

A post for a laparoscopic nurse practitioner was set up to ensure that minimal invasive surgery was available to patients. Steps were taken to define - very carefully - the role and tasks expected of the nurse practitioner. Training was provided to enable the nurse practitioner to fulfil this role and to ensure that other members of the team understood it. A detailed clinical protocol defined standards of care, treatment, and the roles of members of the clinical team.

Nurse practitioners have clinical autonomy and enhanced status within the clinical team. They are accountable to the surgeon and - professionally - to the Director of Nursing. Their presence enables clinical work to proceed even when the Consultant is away from the hospital, such as at training events or on annual leave. Because of the advanced level of practice, nurse practitioners have been recognised and paid appropriately (grade H).

The development was not without problems - many an inevitable consequence of introducing a new member to the clinical team. Detailed analysis was required to ensure that the 'case' for the initial investment was strong - and successful. Nurse practitioners are now active in a range of situations in the hospital, in urology, and stoma and breast care.

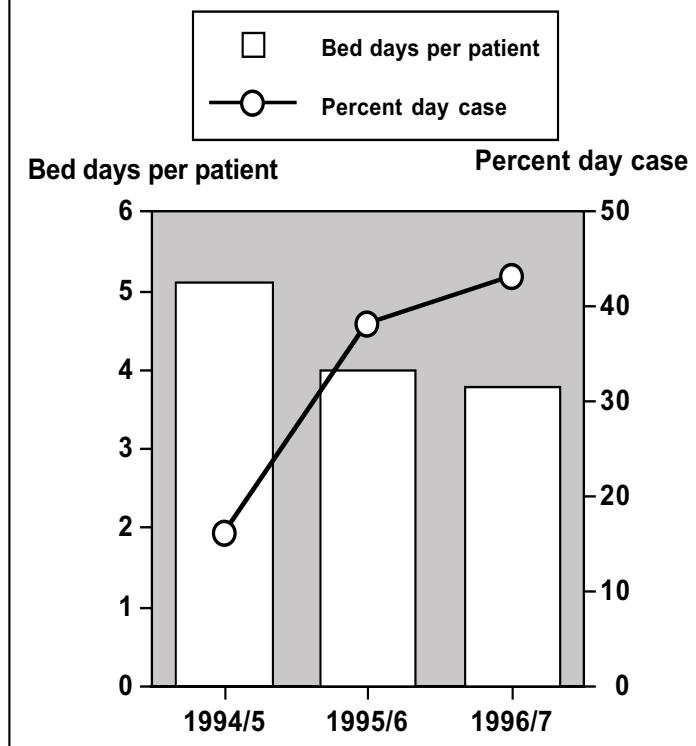
Does it work?

Experience has shown that benefits can be seen in four areas:

- 1 Better care for patients - surveys have shown that patients have welcomed the changes. They like the 'familiar face' - from pre-admission assessment to post-discharge follow-up. Patients also welcomed the follow-up telephone call after discharge to check-up that all was well. Again the familiar voice - the nurse practitioner - was valued.

- 2 More effective care and treatment - audits (in laparoscopic surgery) have shown a reduction in the number of 'DNAs - did not attend'; an increase in the proportion of patients managed as day patients (up over twofold); a 25% reduction in the length of stay for cholecystectomy patients (down from 5.1 to 3.8 days) and fewer patients are now found to require open surgery (over three years this 'conversion' is down from 16% to 2%).
- 3 Better job satisfaction and appropriate rewards for nurse practitioners. The initiative ensures more appropriate use of clinical skills and clinical time.
- 4 Better training for junior doctors - they can move through the full training cycle - from observation to application - within their six months placement. The clinical support available from the nurse practitioner is an important factor.

Impact of nurse practitioners on laparoscopic cholecystectomy - bed days and day cases



Tips for success

- ✓ Be careful with terminology and the use of titles - be clear what you mean when you use the title 'nurse practitioner'.
- ✓ Ensure that the role is defined and adequate training and rewards are available.
- ✓ Ensure that the role of the nurse practitioner is clearly understood by other members of the clinical team. Be clear what it means for junior doctors and other nursing staff. Teams only work well when each individual member understands their own distinctive role and the impact of that on others: time devoted to training and communications will be well spent.
- ✓ Training enables staff who have not been through medical training to deliver effective care - as long as the task is clearly defined.

✓ The costs of employing a nurse practitioner can be recovered by reduced bed costs - although, as these are marginal costs, redeployment of the resources across the organisation may not be practical - but they contribute to greater efficiency.

To find out more contact:

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A number of documents have developed which contain a considerable amount of useful information. Specifically, the following documents are available, and would be useful for anyone considering developing a nurse practitioner service in secondary care:

- Clinical protocols
- Job descriptions
- Patient information
- Pre-assessment proforma
- Clinical audit data

ImpAct bottom lines

- ⇒ Avoid the careless use of meaningless titles
- ⇒ Devote effort and time to training and team building

EXPLORING THE ROLE OF THERAPY ASSISTANTS

Improving amputee rehabilitation and exploring new roles in Bradford Hospitals

Why was the initiative launched?

Local service managers wanted to improve rehabilitation services for patients needing lower limb amputations. They decided to examine of ways of improving inter-disciplinary team working and to evaluate the potential improvement to care from having a therapy assistant. Two factors seemed to be delaying or preventing recovery: protracted in-patients stays and limited access to therapy activities. The management of lower limb amputees was being provided within a busy, acute vascular unit. But, perhaps inevitably, the needs of acutely ill patients took precedence over patients with less acute needs. A review of the literature pointed to the benefits of better team working. An earlier local initiative had demonstrated the benefits from increased therapeutic input to rehabilitation following elective orthopaedic surgery.

What was done?

The development of the job specification for ward-based therapy assistants was the first task. A detailed analysis, by senior local clinicians, of specific clinical tasks identified those that could be delegated to a competently trained, non-professional assistant. Subsequently, staff were recruited and trained activities in the physiotherapy, occupational therapy and nursing skills related to amputees.

The job specification (for therapy assistants) required that they be employed on a seven day week basis - recovery should not be put on hold at 5 o'clock on Fridays! It guaranteed a real increase in the amount of therapeutic activity undertaken by patients. A six-bedded intensive therapy bay in the acute vascular ward provided the working base for the therapy assistants. It was equipped for patients needing rehabilitation after amputation. Evidence suggested that keeping patients together the improved patients' morale and speeded their recovery.

Initiatives to improve inter-disciplinary team performance focused on improving communications between team members. Training ensured that the distinctive roles of individual

Effect of ward-based therapy assistants in lower limb amputation

Outcome	Before the new service	After the new service
Admission to discharge (days)	43.4	25.5
Number of patients surveyed	47	21
Rehabilitation activities observed (percent of time)	4.7	38.9
Number of patients surveyed	12	5

team members were understood - in particular to ensure that other disciplines were clear about the role and contribution of therapy assistants. Weekly inter-disciplinary team meetings were organised to review the needs of individual patients: a social worker was key member of the team. Factors that might affect discharge were given particular attention.

Earlier patient surveys about the information they received about their operation and rehabilitation had recorded mixed views from patients about its quality. There was inadequate information about the reasons for amputations and about social security benefits. A series of semi-structured interviews with a group of patients (focus groups) helped guide the development of improved patient information material. This gives patients comprehensive and understandable information about rehabilitation.

Did it work?

The work has confirmed that the employment of therapy assistants can speed the rehabilitation and earlier discharge of patients following lower limb amputation. Evaluation of the initiative - using comparative information from the previous year - has shown that:

- ◆ The length of stay of patients - from admission to discharge - has fallen for patients treated on the therapy intensive unit. It is down from an average of about 43 to 25 days, an average reduction of 18 fewer days less in hospital for each patient.
- ◆ The amount of time spent by patients in therapeutic activity has increased dramatically - a ten-fold increase between the pre and project time: up from about 5% to about 39%.
- ◆ The time spent by patients alone - rather than in contact with other patients - has decreased significantly.
- ◆ The response from patients to the new patient information has been very positive - they felt they were well supported in the new unit.

ImpAct bottom lines

- ⇒ Exploring ways to use therapy assistants offers practical and economic opportunities to improve the quality of care to patients
- ⇒ Effective inter-disciplinary work requires understanding and communication between team members - it must be worked at: it will not happen by magic.

WELCOME TO THE NHS LEARNING NETWORK!

Isn't it interesting that while there has been such a push towards evidence-based practice, there has been far less emphasis on evidence-based service delivery and management? For example, there is much more research on how to treat an individual patient with diabetes than how to run a good diabetic service for a population. The NHS is implementing a huge programme of change. Clinical staff are taking on new roles - expanding their horizons towards shaping services for populations. They are getting more involved in management. The need for excellence in management and service delivery has never been greater.

Tips for success

- ✓ Therapy assistants - non-qualified staff trained to provide a limited range of clinical interventions - can be effective and may have relevance in other clinical settings.
- ✓ Experience has shown that it was not practical to include nursing responsibilities within the job description for therapy assistants - it placed difficult pressures on staff - being 'torn between care for patients requiring acute care and rehabilitation'.
- ✓ Good communications are one of the keys to good interdisciplinary work. Ensure that role boundaries are clear.
- ✓ Handle communications with patients carefully - encourage all members of the team to keep within the care plan for the patient agreed by the team - avoid 'ad hoc' comments - for example about likely discharge dates.
- ✓ Patients and carers can provide valuable contributions to service developments.

To find out more contact

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The following material is available:

- Job description
- Competency manual
- Patient information

Evidence about management it is not easy to find. In the absence of hard evidence, wouldn't it be helpful to find out how others in the NHS have tried to improve a service - and be able to learn from their experience? For example, to help Primary Care Groups across the country learn from each other about how they are tackling a common priority, like managing emergency admissions.

The service is buzzing with good ideas and experiments in service delivery. The challenge is to spread information about them, to learn from the best, and to develop the management skills on which they are based. The NHS Learning Network aims to do just this. Spreading good practice in service delivery is the main objective of the NHS Learning Network. It has four main elements:

- 1 Supporting intelligence – providing information and evidence about service delivery solutions.
- 2 Learning Centres – providing opportunities for people to learn from one another.
- 3 Management Training – strengthening the core knowledge base of management in the NHS and increasing access to training for clinical staff.
- 4 Leadership – developing clinical and non-clinical leaders.

Supporting intelligence

A National Database of Service Delivery Practice is being piloted in a newly developed 'Learning Zone' on the NHS Web. The database is designed for NHS staff to enter and search for examples of good practice in service delivery. For example, details of all Beacon Services will be available. Information will also held about learning opportunities. You can search the database provided you have access to the NHS Web - and you can enter information. More details about the database are provided in HSC 1999 110.

A national NHS Management Forum is being set up to review promising new management interventions and to encourage their evaluation. We will ensure that you hear about the results of these evaluations.

Two new NHS R&D programmes have been launched which could add to the evidence-base for service delivery and management. These are the Service Delivery and Organisation Programme and the new Human Resources R&D programme.

ImpAct is part of this 'supporting intelligence'. It is being funded to report on examples of good practice in service delivery - identified through the database or otherwise.

Learning centres

We are funding the setting up of Learning Centres, one to each Region, to encourage hands-on practical learning about good practice in service delivery. These will be NHS organisations which have, either:

- ◆ attempted a significant change to service delivery and management and a track record in telling others about it; or
- ◆ significant skills in encouraging peer group learning on service delivery issues.

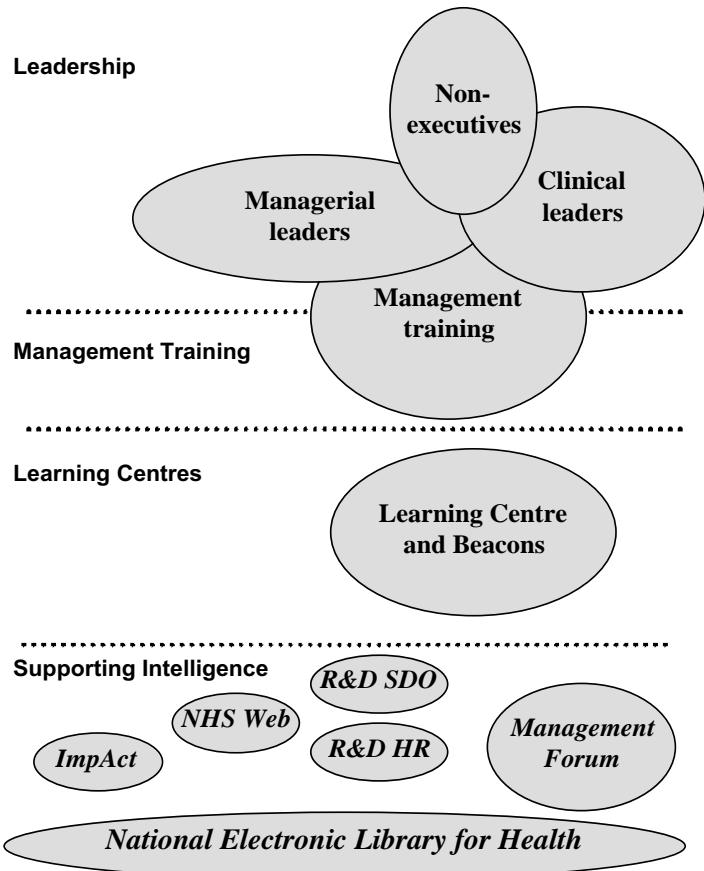
Management training

We are reviewing management training opportunities for NHS staff. Our aims are to strengthen the content and evidence-base of existing training (influenced by other elements of the Learning Network) and to increase access to training for clinical staff (for example through the Learning Centres).

Leadership

Developing effective leaders in the NHS is a priority. We are looking at ways of building on the strengths of current pro-

The NHS Learning Network



grammes, such as the NHS Leadership Development Programme for Chief Executives, the work of the British Association of Medical Managers, and nurse leadership training.

Progress

We have made a good start. Browse the Database – search it to find examples useful to you, and network with colleagues! Go and visit a 'Beacon'. Look out for news of your region's Learning Centres. Ask your local education and training representative, or Regional Office, about opportunities to sharpen up your management skills.

But, this is just the beginning. Through *ImpAct* and in other ways we will keep you in touch with progress.

Jennifer Dixon
NHS Executive

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